ACE Inhibitors, Angiotensin Receptor Blockers, Beta-Blockers

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?
   Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval

   Document clinically compelling information

2. The requested medication may be approved if both of the following are true:
   - If there has been a therapeutic failure of no less than a **one-month trial** of at least **one** medication **within the same class** not requiring prior approval
   - The requested medications corresponding generic (if a generic is available and covered by the State) has been attempted and failed or is contraindicated

ADDITIONAL INFORMATION TO AID IN FINAL DECISION

If there is a specific indication for a medication requiring prior approval, for which medications not requiring prior approval are not indicated, then may approve the requested medication.
Document details
This medication should be reviewed for need at each request for reauthorization.

Angiotensin Receptor Blockers and Combinations

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Cozaar® ***(Losartan Potassium) ****	Atacand®
Diovan®	Atacand HCT®
Diovan HCT®	Avalide®
Hyzaar®	Avapro® ***(Irbesartan) ****
	Benicar®
	Benicar HCT®
	Micardis®
	Micardis HCT®
	Teveten®
	Teveten HCT®

Drug lists continued on next page.

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

ACE Inhibitors, Angiotensin Receptor Blockers, Beta-Blockers (continued page 2)

ACE Inhibitors and Combinations

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Benazepril	Accupril®
Benazepril/HCTZ	Accuretic®
Captopril	Aceon®
Captopril/HCTZ	Altace Capsule®
Enalapril	Altace Tablet®
Enalapril/HCTZ	Capoten®
Lisinopril	Capozide®
Lisinopril/HCTZ	Fosinopril
	Fosinopril/HCTZ
	Lotensin®
	Lotensin HCT®
	Mavik®
	Moexipril
	Monopril®
	Monopril HCT®
	Moexipril/HCTZ
	Prinivil®
	Prinzide®
	Quinapril
	Quinaretic®
	Ramipril
	Trandolapril
	Uniretic®
	Univasc®
	Vaseretic®
	Vasotec®
	Zestoretic®
	Zestril®

ACE or ARB plus Calcium Channel Blocker Combinations

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Lotrel®	Amlodipine/Benazepril
	Azor®
	Exforge®
	Lexxel®
	Tarka®
	Teczem®

Drug lists continued on next page.

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

ACE Inhibitors, Angiotensin Receptor Blockers, Beta-Blockers (continued page 3)

Beta Blockers and Combinations

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Acebutaolol	Betapace®
Atenolol	Betapace AF®
Atenolol/Chlorthalidone	Blockadren®
Betaxolol	Bystolic®
Bisoprolol Fumarate	Cartrol®
Bisoprolol/HCTZ	Coreg®
Carvedilol	Coreg CR®
Labetalol	Corgard®
Metoprolol/HCTZ	Corzide®
Metoprolol tartrate	Inderal®
Nadolol	Inderal LA®
Pindolol	Inderide®
Propranolol Solution	Innopran XL®
Propranolol	Kerlone®
Propranolol/HCTZ	Levatol®
Sorine®	Lopressor®
Sotalol	Lopressor HCT®
Sotalol AF	Metoprolol succinate
Timolol Maleate	Nadolol/Bendroflumethiazide
	Normodyne®
	Sectral®
	Tenoretic®
	Tenormin®
	Timolide®
	Toprol XL®
	Trandate®
	Zebeta®
	Ziac®

TOPROL XL®: Authorize if any of the following are true
• Toprol XL® 25mg po qd will be authorized as it would not be feasible to promote metoprolol 12.5mg po BID. Toprol XL® 25mg will be authorized with a quantity limit of 45 tablets per 30 days.
• Doses >37.5 mg Toprol XL® po qd will be offered a change to metoprolol in a total daily dose divided by two and dosed BID
• If patient compliance is questioned or compromised by change, then the Toprol XL® will be authorized

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Antibiotics: Oral Cephalosporins, Macrolides, Quinolones

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?
   Acceptable reasons include:
   Allergy to product formulation (i.e. dyes, fillers). If an allergy to drug class, should question medication request.
   Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   History of unacceptable/toxic side effects to medications not requiring prior approval
   Document clinically compelling information

2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication. Document details.
   - Note diagnosis and any culture and sensitivity reports

3. If there has been a therapeutic failure to no less than a **three-day** trial of **one** medication within the same not requiring prior approval, then may approve the requested medication. Document details.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.

If the patient requires a prior authorized medication based on a specific medical need that is not covered by the FDA indications of the preferred medications, then allow the non-preferred medication. This information should be reviewed at each request for reauthorization.

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Second Generation Quinolones	
Ciprofloxacin	Cipro®
Cipro® Suspension	Ciprofloxacin Suspension
	Cipro XR®
	Ciprofloxacin ER
	Floxin®
	Maxaquin®
	Noroxin®
	Ofloxacin
	Proquin XR®
Third Generation Quinolones	
Avelox®	Factive®
Avelox ABC PACK®	Levaquin®
	Levaquin Suspension ®
	Proquin XR®
	Zagam®

Drug lists continued on next page.

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Antibiotics : Oral Cephalosporins, Macrolides, Quinolones *(page 2)*

Preferred Drugs - No PA Required	Non-Preferred Drugs - PA Required
Second Generation Cephalosporins	
Cefaclor Capsule	~~Ceclor®~~ no longer available
Cefaclor suspension	~~Ceclor® CD~~ no longer available
Cefaclor ER	Ceftin® tablets
Cefprozil	Ceftin® suspension
Cefprozil Suspension	Cefzil®
Cefuroxime tablets	Cefzil® Suspension
~~Lorabid®~~ no longer available	
~~Lorabid® Suspension~~ no longer available	
Raniclor®	
Third Generation Cephalosporins	
Cedax Capsule®	Cefpodoxime Proxetil
Cedax® Suspension	Cefpodoxime Proxetil Suspension
Cefdinir Capsule	Omnicef ®Capsules
Cefdinir Suspension	Omnicef® Suspension
Spectracef®	Suprax Susp®
	Vantin®
	Vantin Suspension ®
Macrolides	
Azithromycin	Biaxin®
Azithromycin Packet	Biaxin® Suspension
Azithromycin Suspension	Biaxin XL®
Clarithromycin	Dynabac®
Clarithromycin ER	E.E.S. ®
Clarithromycin Suspension	ERYC®
Erythrocin stearate	Eryped®
Erythromycin base	Ery-tab®
Erythromycin ethylsuccinate	Ketek® **
Erythromycin estolate suspension	PCE®
Erythromycin stearate	Zithromax® Suspension
Erythromycin with sulfisoxazole	Zithromax®
	ZMAX® suspension

** To receive a PA for Ketek®,

- A specific Ketek PA request form must be completed and faxed or mailed to First Health Services with the physician's signature. By signing this request, the physician accepts understanding of the contraindications and warnings with the use of Ketek and acknowledges that the benefits of the drug outweigh the possible risks. A copy of the PA form is available at http://www.dmas.virginia.gov/pharm-pdl_program.htm or at http://virginia.fhsc.com. The PA may also be completed online at: https://webpa.fhsc.com/webpa .
- Recipient must be 18 or over and can only be approved for an FDA indication

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Antibiotics: Topical

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?
   Acceptable reasons include:
   Allergy to product formulation (i.e. dyes, fillers). If an allergy to drug class, should question medication request.
   Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   History of unacceptable/toxic side effects to medications not requiring prior approval
   Document clinically compelling information

2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication. Document details.
   - Note diagnosis and any culture and sensitivity reports

3. If there has been a therapeutic failure to no less than a **three-day** trial of **one** medication within the same class not requiring prior approval, then may approve the requested medication. Document details.

Topical Antibiotics

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Mupirocin Ointment	Altabax® **
	Bactroban Cream®

** Has a 5 gram per 34 day quantity limit once a PA is authorized.

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Antifungals (Oral) for Onychomycosis

LENGTH OF AUTHORIZATIONS: For the duration of the prescription (up to 6 months)

Is there any reason the patient cannot be changed to a medication not requiring prior approval? Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval.
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

If the patient has a serious illness that causes them to be immunocompromised (i.e. AIDS, cancer, etc.) then may approve the requested medication.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

1. If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital or other similar location, or if the patient has just become Medicaid eligible and is already on a course of treatment with a medication requiring prior approval, then may approve the requested medication.

2. If the request is for a diagnosis other than fungal infection, please refer to a clinical pharmacist.

Sporanox

If Sporanox is requested for any other FDA approved indication (other than onychomycosis), then approve for 6 months or the duration of the prescription.

Indications: Aspergillosis, Candidiasis (oral or esophageal), Histoplasmosis, Blastomycosis, empiric treatment of febrile neutropenia

A PA for Lamisil ® granules may be granted if

- Recipient is over 4 years of age
- Diagnosis is ***tinea capitis***

Lamisil® oral granules are FDA approved for the treatment of ***tinea capitis*** *(also called ringworm of the scalp) in patients 4 years of age and older. (Lamisil® oral tablets (250mg) are FDA approved for the treatment of* ***tinea unguium****- onychomycosis but not* ***tinea capitis*** *ringworm****).***

ORAL ANTIFUNGALS USED FOR ONYCHOMYCOSIS

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Terbinafine	Itraconazole
	Lamisil®
	Lamisil ® Granules (diagnosis ***tinea capitis)***
	Sporanox® Solution
	Sporanox® Capsules

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Low Sedating Antihistamines: Second Generation

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. If there has been a therapeutic failure after a course of treatment (e.g., one month for allergic rhinitis) with one product not requiring prior approval, then may approve the requested medication. Document details

Second Generation Antihistamines and Combinations

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Claritin OTC®	Allegra®
Claritin OTC® Syrup	Allegra ODT®
Claritin Tablets- Rapids OTC®	Allegra Suspension ®
Claritin-D 24hr OTC®	Allegra-D 12 hr®
Claritin-D 12 hr OTC®	Allegra-D 24 hr®
Loratadine tablet (represents all OTC names)	Cetirizine Chew OTC
Loratadine Tab- Rapids (represents all OTC names)	Cetirizine Syrup OTC no PA required < 2yrs of age
Loratadine Syrup (represents all OTC names)	Cetirizine Tablet OTC
Loratadine D 24hr (represents all OTC names)	Cetirizine D Tablet OTC
Loratadine D 12 hr (represents all OTC names)	Clarinex Table® *(Desloratadine)*
	Clarinex Tablet Rapids®
	Clarinex® syrup
	Clarinex- D® 24 hr
	Clarinex- D® 12 hr
	Claritin-D® - Rx forms
	Claritin® - Rx forms
	Fexofenadine
	Fexofenadine/PSE
	Xyzal®
	Zyrtec Tablet OTC/RX ®
	Zyrtec Tablet Chew OTC/RX ®
	Zyrtec® syrup OTC/RX no PA req < 2yrs of age
	Zyrtec-D® OTC/RX

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Antimigraine Medications: Serotonin Receptor Agonists "Triptans"

LENGTH OF AUTHORIZATIONS: 6 months

1. Is there any reason the patient cannot be switched to a non-prior approved medication?

Acceptable reasons include:

- Allergy to **one** of the non-prior approved products
- Contraindication to all non-prior approved product(s)
- History of unacceptable side effects to **one** of the non-prior approved product(s)

Document clinically compelling information

2. Has the patient had therapeutic trial of **one** non-prior authorized drug that failed? If so, document and allow the prior authorized medication.

CLINICAL CONSIDERATIONS:

Prior Authorization will not be given for prophylactic therapy of migraine headache unless the patient has exhausted or has contraindications to all other "controller" migraine medications (i.e., beta-blockers, calcium channel blockers, etc) and the physician and patient are aware of the adverse risk potential.

Triptans

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Imitrex Cartridge®	Amerge®
Imitrex Nasal®	Axert®
Imitrex Pen Kit®	Frova®
Imitrex Tablets® ***(Sumatriptan Succinate) ****	Relpax®
Imitrex Vial®	***(Treximet®)****
Maxalt®	Zomig Tablets®
Maxalt MLT®	Zomig nasal spray®
	Zomig ZMT®

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Antivirals: Herpes

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient's condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient's condition.

Document clinically compelling information

2. If there has been a therapeutic **failure of a trial of at least one medications** not requiring prior approval, then may approve the requested medication.

Antivirals: Herpes

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Acyclovir Tablets	Famciclovir
Acyclovir Susp	Zovirax Susp®
Famvir ®	Zovirax Tablet ®
Valtrex ® ***(Valacyclovir) ****	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Antivirals: Influenza

LENGTH OF AUTHORIZATIONS:

- For diagnosis of influenza the authorization is for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient's condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient's condition.

Document clinically compelling information

2. If there has been a therapeutic **failure of a trial of at least one medications** not requiring prior approval, then may approve the requested medication.

Antivirals: Influenza

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Amantadine	Flumadine®
Amantadine Syrup	Flumadine Syrup®
Relenza Disk®	~~Symmetrel~~ No longer available
Rimantadine	~~Symmetrel Susp~~ No longer available
Tamiflu®	
Tamiflu Susp®	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Antivirals: Interferon for Hepatitis C

LENGTH OF AUTHORIZATIONS: SEE BELOW

Clinical PA for initial 16 week PA:

1. **Initial approval periods should be limited to 16-weeks and viral titer should be obtained at week 12 of therapy.**

Clinical PA for established HCV reactors:

2. Therapy is approvable for a total of 24 weeks in patients that are HCV genotypes 2 or 3 who have achieved a virologic response (either undetectable HCV RNA [<50 IU/mL] or at least a 2-log drop in HCV RNA titer from baseline) at 12 weeks of treatment.
3. Therapy is approvable for total of 48 weeks in HCV genotype 1 or 4 patients who have achieved a virologic response (either undetectable HCV RNA [<50 IU/mL] or at least a 2-log drop in HCV RNA titer from baseline) at 12 weeks of treatment.
4. If patients fail to achieve a virologic response by 12 weeks, further treatment is not indicated.

PDL PA

1. Is there any reason the patient cannot be started on a medication not requiring prior approval?

   Acceptable reasons include:
   - Allergy to product formulation (i.e. dyes or fillers). If an allergy to drug class, should question medication request.
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval

   Document clinically compelling information

2. Has there been a therapeutic failure after a reasonable therapeutic trial with use of **one** of the non-prior authorized agents? Document the details, and forward all of these requests to a clinical pharmacist.

Additional Information:

1. **Copegus®** and **Rebetol®** are oral ribavirins. Oral ribavirin therapy is not effective for the treatment of chronic hepatitis C viral infection and should not be used alone for this indication.

2. **Pegasys®** and **PEG-Intron®** are pegylated Interferons.

Antivirals: Interferon

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Pegasys	
Pegasys Conv.Pack	
Peg-Intron	
Peg-Intron Redipen	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Beta-Adrenergic Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class and formulation?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. If there has been a therapeutic failure to no less than a **two-week** trial of at least **one** medication not requiring prior approval **within the same class and formulation**. (ie nebulizers for nebulizers) Document details

ADDITIONAL INFORMATION

Patients experience cardiac and central nervous system side effects (i.e. tachycardia, agitation) more often.

Beta Adrenergic Agents

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Short Acting and Combination Metered Dose Inhalers or Devices	
Albuterol	Proventil®
Alupent MDI	Ventolin®
Combivent® MDI	Albuterol HFA
Maxair® Autohaler	Proair® HFA
Proventil ®HFA	
Ventolin® HFA	
Xopenex® HFA	
Long Acting Metered Dose Inhalers or Nebulizers	
Foradil®	Brovana®
Serevent Diskus®	Perforomist®
Short Acting Nebulizers	
Accuneb® pediatric dosing, premixed nebs	Proventil®
Albuterol Sulfate *premix & concentrate*	
Metaproterenol	
Xopenex®	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Calcium Channel Blockers:
Dihydropyridine Calcium Channel Blockers and Non-dihydropyridine Calcium Channel Blockers

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class and formulation?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. The requested medication may be approved if both of the following are true:
    - If there has been a therapeutic failure to no less than a one-month trial of at least one medication within the same class not requiring prior approval
    - The requested medications corresponding generic (if a generic is available and covered by the state) has been attempted and failed or is contraindicated

CLINICAL NOTES

There are two main classes of Calcium Channel Blockers (each with different actions on the peripheral vasculature and cardiac tissue):

1. Dihydropyridine Calcium Channel Blockers (DHPCCB)
2. Non-Dihydropyridine Calcium Channel Blockers (NDHPCCB)

Vascor is in its own third class of Calcium Channel Blockers and not included under PA requirements on the VA PDL at this time.

See next page for specific drug lists.

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Calcium Channel Blockers: *Dihydropyridine Calcium Channel Blockers and Non-dihydropyridine Calcium Channel Blockers* (Continued)

Calcium Channel Blockers

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Dihydropyridine Calcium Channel Blockers	
Afeditab CR®	Adalat CC®
Amlodipine	Cardene®
Dynacirc CR®	Cardene SR®
Felodipine ER	Dynacirc®
Nicardipine	Norvasc®
Nifediac CC®	Procardia®
Nifedical XL®	Procardia XL®
Nifedipine	
Nifedipine ER	
Nifedipine SA	
Plendil®	
Sular® *(*Nisoldipine)*	
Non-Dihydropyridine Calcium Channel Blockers	
Cartia XT®	Calan®
Diltia XT®	Calan SR®
Diltiazem	Cardizem®
Diltiazem ER q 24hr dose	Cardizem CD®
Diltiazem ER q 12hr dose	Cardizem LA®
Diltiazem XR	Cardizem SR®
Taztia XT®	Covera HS®
Verapamil	Dilacor XR®
Verapamil SA	Diltiazem SR q 12hr dose
Verapamil 24hr pellets	Isoptin SR®
	Isradipine ®
	Tiazac®
	Verelan®
	Verelan PM®

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Central Nervous System Stimulants/ADHD Medications

LENGTH OF AUTHORIZATION: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?
Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. If there has been a therapeutic failure to no less than a **one-month trial** of at least **one** medication not requiring prior approval, then may approve the requested medication. Document details.

3. The patient must have failed the generic product (if covered by the State) before the brand is authorized.

4. If the patient requires a prior authorized medication based on a specific medical need that is not covered by the FDA indications of the preferred medications, then allow the non-preferred medication. This should be reviewed for need at each request for reauthorization.

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Amphetamine Products	
Adderall XR®	Adderall®
Amphetamine Salts combo	Desoxyn®
Dextroamphetamine	Dexedrine®
Dextroamphetamine SR	~~Dexedrine spansule®~~ No longer a valuable
Dextrostat®	
Methylphenidate Products	
Concerta®	Daytrana™ Transdermal
Focalin®	Dexmethylphenidate
Focalin XR®	Ritalin®
Metadate CD®	Ritalin SR®
Metadate ER®	
Methylin®	
Methylin chew®	
Methylin ER®	
Methylin solution®	
Methylphenidate	
Methylphenidate SR	
Ritalin LA®	
Vyvanse®	
Miscellaneous Products	
Strattera®	Provigil®
	(Nuvigil) *

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Corticosteroids: Inhaled and Nasal Steroids

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient's condition is clinically unstable—patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days—changing to a medication not requiring prior approval might cause deterioration of the patient's condition.

Document clinically compelling information

2. If there have been therapeutic failures to no less than **one-month** trials of at least **two** medications not requiring prior approval, then may approve the requested medication.
   Document details

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

1. If a medication requiring prior approval was initiated in the hospital, and then may approve the requested medication.
   Document details

2. If the patient is a child <13 years old or a patient with a significant disability, and unable to use an inhaler which does not require prior approval, or is non-compliant on an inhaler not requiring prior approval because of taste, dry mouth, infection; then may approve the requested medication.
   Document details

See next page for specific drug lists.

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Corticosteroids: Inhaled and Nasal Steroids (Continued page 2)

Inhaled Corticosteroids

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Metered Dose Inhalers	
Aerobid®	Flovent Rotadisk®
Aerobid M®	Flovent®
Asmanex®	Pulmicort Flexhaler®
Azmacort®	
Flovent HFA®	
Flovent Diskus®	
QVAR®	
Nebulizer Solution	
Pulmicort Respules®	
Combination Products (Glucocorticoid and Beta Adrenergic)	
Advair Diskus	Symbicort®
Advair HFA	

Nasal Steroids

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Flunisolide	Allemist®
Fluticasone	Beconase AQ®
Nasacort AQ®	Flonase®
Nasonex®	Nasacort®
	Nasarel®
	**(Omnaris®)*
	Rhinocort AQUA®
	Tri-Nasal®
	Veramyst®

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

COPD: Anticholinergics

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient's condition is clinically unstable—patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days—changing to a medication not requiring prior approval might cause deterioration of the patient's condition.

Document clinically compelling information

2. If there have been therapeutic failures to no less than **one-month** trials of at least **two** medications not requiring prior approval, then may approve the requested medication.
   Document details

COPD Anticholinergics

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Atrovent AER®	Duoneb®
Atrovent HFA®	Ipratropium/Albuterol
Combivent® MDI	
Ipratropium Bromide Solution	
Spiriva®	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

COX-2 Inhibitors

Clinical edit

LENGTH OF AUTHORIZATIONS: 1 year

The preferred product may be approved for patients if one of the following is true:

- If there has been a therapeutic trial and failure on a minimum of two (2) different non-COX2 NSAIDs
- Concurrent use of anticoagulants (warfarin or heparin)
- Chronic use of oral corticosteroids
- Concurrent use of methotrexate
- History of previous GI bleed or conditions associated with GI toxicity risk factors (i.e., PUD, GERD, etc.)
- If there is a specific indication for medication requiring prior approval, for which medications not requiring prior approval are not indicated, then document details and refer caller to a clinical pharmacist
- Patients with a diagnosis of familial adenomatous polyposis (FAP) presenting with a prescription for celecoxib (Celebrex®) may be approved without any risk factors or trials on NSAIDs.

CRITICAL INFORMATION TO CONSIDER

1. Selective cyclooxygenase-2 (COX-2) inhibitors are known to inhibit the production of vascular prostacyclin (PGI2), an inhibitor of platelet aggregation and a vasodilator. Unlike conventional non-steroidal anti-inflammatory drugs, COX-2 inhibitors do not reduce the endogenous production of thromboxane A2, a potent platelet activator and aggregator, thereby causing a potentially prothrombotic cascade of events that could lead to a significant increase in the risk for thrombotic cardiovascular events (myocardial infarction, occlusive stroke) in patients receiving celecoxib therapy. **Therefore, it is advisable to exercise caution when prescribing celecoxib, a COX-II inhibitors to patients with a higher risk of cardiovascular disease.**

2. If the patient is allergic to one NSAID or aspirin, the patient may be allergic to other NSAIDs.

3. If allergic to sulfonamides, a patient should not receive Celebrex®.

Cox-2 Inhibitors

Preferred Drugs - PA Required	Non-preferred Drugs - N/A
Celebrex®	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Electrolyte Depleters

LENGTH OF AUTHORIZATIONS: 1 year

2. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient's condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient's condition.

Document clinically compelling information

2. If there has been a therapeutic **failure to at least a one-month trial of at least one medication** not requiring prior approval, then may approve the requested medication.

Electrolyte Depleters

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Fosrenol®	Renvela®
Phoslo®	
Renagel®	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Gastrointestinals: Histamine -2 Receptor Antagonists (H-2 RA)

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient's condition is clinically unstable—patient has had an ER visit or at least two hospitalizations for asthma in the past thirty days—changing to a medication not requiring prior approval might cause deterioration of the patient's condition.

Document clinically compelling information

2. If there has been a therapeutic failure to no less than a **one-month trial** of at least **one** medication not requiring prior approval, then may approve the requested medication.
   Document details

3. If a medication requiring prior approval was initiated in the hospital for the treatment of a condition such as a GI bleed, and then may approve the requested medication.
4. Treatment of warts is not an FDA approved diagnosis or indication for Tagamet / cimetadine and a PA will not be approved for this diagnosis or indication.

H2 Receptor Antagonists

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Famotidine	Axid Capsule ®
Ranitidine	Axid Solution®
Ranitidine syrup	Cimetidine Syrup
	Cimetidine Tablet
	Nizatidine
	Pepcid Oral Suspension®
	Pepcid Tablet®
	Tagamet®
	Zantac Tablet®
	Zantac® syrup *no PA required for age < 12yrs*

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Gastrointestinals: Proton Pump Inhibitors

LENGTH OF AUTHORIZATIONS:

- Prilosec® OTC, if successful, may be continued with no limitations to duration of therapy
- Protonix® (Pantoprazole) to be approved for 120 days (if 60-day trial of Prilosec® OTC fails)
- Non-preferred products to be approved for 120 days (with failure of both Prilosec® OTC and Protonix® or Pantoprazole)
- *For exceptions see criteria for "Proton Pump Inhibitors exception"*

1. Step one requires a therapeutic failure of a **60-day trial** of OTC Prilosec® (up to 40mg daily). For exceptions to this see criteria for "Proton pump inhibitors exception".
   Other things to consider when reviewing OTC Prilosec®
   - Allergy to Omeprazole
   - Contraindication to or drug-to-drug interaction with OTC Prilosec® (Omeprazole)
   - History of unacceptable/toxic side effects to OTC Prilosec® (Omeprazole)
   - Patient's condition is clinically unstable; changing to OTC Prilosec® might cause deterioration of the patient's condition.

   Document details

2. If has failed step one then move to step two and the other preferred medication, Protonix® (Pantoprazole) must be tried. If there is a therapeutic failure of no less than a **one-month trial** with Protonix® (Pantoprazole) then may approve the requested medication for duration of 120 days.
   Other things to consider when reviewing
   Is there any reason the patient cannot be changed to Protonix®, Acceptable reasons include:
   - Allergy to Protonix® (Pantoprazole)
   - Contraindication to or drug-to-drug interaction with Protonix®(Pantoprazole)
   - History of unacceptable/toxic side effects to Protonix® (Pantoprazole)
   - Patient's condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient's condition.

   Document details

Gastrointestinals: Proton Pump Inhibitors exceptions

LENGTH OF AUTHORIZATIONS: **If an exception is met, approve desired product and make the duration for 1 year. Step therapy requirements detailed above do not apply.**

EXCEPTIONS

- Erosive Esophagitis
- Active GI Bleed
- Zollinger-Ellison Syndrome
- Greater than 65 years of age
- If Failed 120 day trial and is under the care of a Gastroenterologist and has Ruled out a nonsecretory Condition

Document details

See next page for specific drug lists.

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Gastrointestinals: PPIs (see step edit)

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Protonix®	Aciphex® ***(rabprazole)***
Prilosec OTC® **	Nexium®
	Omeprazole *no PA req age < 12yrs*
	Pantoprazole
	Prevacid® caps *no PA req age < 12yrs*
	Prevacid® susp *no PA req age < 12yrs*
	Prevacid® solutab *no PA req age < 12yrs*
	Prilosec® Rx form
	Zegerid® Capsule
	Zegerid® effervescent tablet
	Zegerid® susp Packet
	(Zegerid® OTC) *

SPECIAL CONSIDERATION:

Protonix® is a delayed release tablet and cannot be crushed or opened. For tubed patients or patients with swallowing difficulties omeprazole, Prevacid®, Prevacid Solutab®, Prilosec®, Nexium or Prevacid® granules (if oral administration) can be used. These Proton Pump Inhibitors may be opened and the intact granules may be mixed in apple sauce or orange juice and administered. Alternatively, the capsules may be opened and the granules may be dissolved in a small amount of sodium bicarbonate to form a compounded suspension for administration. The omeprazole will be the preferred agent for these circumstances and may be approved.
**If therapy is for a child < 12 then Prevacid® Susp, Prevacid® solutab, Prevacid Caps no PA req age or Omeprazole will not require a PA) If there has been a therapeutic failure on omeprazole or there is a clinical contraindication to omeprazole then another non-preferred agent may be approved.
Aciphex® is an extended release tablet and should not be opened or crushed.

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Growth Hormone Pediatrics

Length of Authorization (pediatrics): 1 year

PEDIATRICS (18 years of age and under)

Clinical Criteria for Approval:
Prescriber is an endocrinologist, nephrologists, infectious disease specialist or HIV specialist or one has been consulted on this case, the patient has open epiphysis and one of the following diagnoses

- Turner Syndrome
- Prader-Willi Syndrome
- Renal insufficiency
- Small for gestational age (SGA) - including Russell-Silver variant and patient is < 2 years old
- Idiopathic Short Stature (for request for renewal only (**a)** information is required to be approved)
- Growth hormone deficiency (physician should provide the required information below)
- Newborn with hypoglycemia and a diagnosis of hypopituitarism or panhypopituitarism.

a. Height is more than 2 SD (standard deviations) below average for the population mean height for age and sex, and a height velocity measured over one year to be 1 SD below the mean for chronological age, or for children over two years of age, a decrease in height SD of more than 0.5 over one year; **AND**

b. Growth hormone response of less than 10ng/ml to at least two provocative stimuli of growth hormone release: insulin, levodopa, L-Arginine, clonidine, or glucagon

Requests for Renewal (pediatrics):

a. For renewal, a response must be documented. Patient must demonstrate improved/normalized growth velocity. (Growth velocity has increased by at least 2 cm in the first year and is greater than 2.5 cm per year), **AND**

b. Patient height is less than 5’ 6" for males or 5' 1" for females, and is more than 1 standard deviation (2") below mid-parental height (unless parental height is diminished due to medical or nutritional reasons).

PDL CRITERIA
1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:
- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

Has there been a therapeutic failure after a reasonable therapeutic trial with use of **one** of the non-prior authorized agents? Document the details, and forward all of these requests to a clinical pharmacist

See **Growth Hormone for all groups for list of preferred/non-preferred**

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Growth Hormone Adults

Length of Authorization: 1 year (Serostim® – 3 months)

ADULTS (> 18 years of age)

Clinical Criteria for Approval:

- Prescriber is an endocrinologist
- Diagnosis of growth hormone deficiency confirmed by growth hormone stimulation tests and rule-out of other hormonal deficiency, as follows: growth hormone response of fewer than five nanograms per mL to at least two provocative stimuli of growth hormone release: insulin, levodopa, L-Arginine, clonidine or glucagon when measured by polyclonal antibody (RIA) or fewer than 2.5 nanograms per mL when measured by monoclonal antibody (IRMA);
- Cause of growth hormone deficiency is Adult Onset Growth Hormone Deficiency (AO-GHD), alone or with multiple hormone deficiencies, such as hypopituitarism, as a result of hypothalamic or pituitary disease, radiation therapy, surgery or trauma
- Other hormonal deficiencies (thyroid, cortisol or sex steroids) have been ruled out or stimulation testing would not produce a clinical response such as in a diagnosis of panhypopituitarism.

- **Zorbtive®**
  - Diagnosis of short bowel syndrome

- **Serostim®**
  - Diagnosis of AIDS Wasting or cachexia
  - Patient has a documented failure, intolerance, or contraindication to appetite stimulants and/or other anabolic agents (both Megace® and Marinol®)
  - **Length of Authorization (Serostim® only):** 3 months initial; then 1 year.
    Renewal is contingent upon improvement in lean body mass or weight measurements.

Requests for Renewal (adults)
Renewal is contingent upon prescriber affirmation of positive response to therapy (improved body composition, reduced body fat, and increased lean body mass).

PDL CRITERIA

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. Has there been a therapeutic failure after a reasonable therapeutic trial with use of **one** of the non-prior authorized agents? Document the details, and forward all of these requests to a clinical pharmacist.

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Growth Hormone Adults & Pediatrics continued pg 3

Growth Hormones for all groups

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Genotropin	Humatrope Cartridge
Norditropin Cartridge	Saizen Vial
Nutropin Aq Cartridge	Tev-Tropin
Nutropin	Humatrope Vial
Nutropin Aq Vial	Saizen Cartridge
Norditropin Nordiflex	Omnitrope

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Glaucoma Agents

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?
   Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval
     Document clinically compelling information

2. The requested medication may be approved if both of the following are true:
   If there has been a therapeutic failure to no less than a **one-month trial** of at least **one** medication **within the same class** not requiring prior approval

3. The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated

Glaucoma Agents

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Alpha 2 Adrenergic Agents	
Alphagan P® 0.1% & 0.15% drops	~~Alphagan® 0.2% drops~~ No longer available
Brimonidine 0.2% drops	
Iopidine® 0.5% & 1% drops	
Beta Blockers	
Betaxolol 0.5% drops	Betagan® 0.25% & 0.5% drops
Betimol® 0.25% &0.5% drops	Istalol® 0.5% drops
Betoptic-S® 0.25% susp drops	Ocupress®1% drops
Carteolol 1% drops	Optipranolol 0.3% drops
Combigan®	Timoptic® drops 0.25% & 0.5% drops
Levobunolol 0.25% & 0.5% drops	Timoptic XE® 0.25% & 0.5% Sol-Gel
Metipranolol 0.3% drops	
Timolol maleate drops 0.25% &0.5% drops	
Timolol maleate 0.5 % Sol-Gel	
Carbonic Anhydrase Inhibitors	
Azopt® 1% drops	
Cosopt® 0.5%-2% drops	
Trusopt® 2% drops	
Prostaglandin Analogs	
Lumigan® 0.03% drops	~~Rescula® 0.15% drops~~ No longer available
Travatan Z® drops	
Travatan® 0.0004% drops	
Xalatan® 0.005% drops ***(Latanoprost)**	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Immunomodulators: Topical

LENGTH OF AUTHORIZATION: 1 YEAR

CLINICAL CONSIDERATIONS:

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?
   Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval

   Document clinically compelling information

2. A PA may only be given for an FDA approved Diagnosis:
   a. **Atopic** dermatitis (a type of eczema) - **FDA approved**:
      • **Elidel®**: mild to moderate for **ages > 2 years.**
      • **Protopic® 0.03%**: moderate to severe for **ages > 2 years.**
      • **Protopic® 0.1%**: moderate to severe for **ages > 18 years.**
   b. All other diagnoses (off-label uses) are to be referred to a clinical pharmacist. **All requests** for all other diagnoses are to be denied.

Critical information for review: Black box warnings are in place for both products as well a requirement for a patient guide to be given with each product dispensed.

The FDA recommends that healthcare providers, patients and caregivers consider the following: (Updated from FDA site 8/29/07) **

- Use Elidel and Protopic only as second-line agents for short-term and intermittent treatment of atopic dermatitis (eczema) in patients unresponsive to, or intolerant of other treatments.
- Avoid use of Elidel and Protopic in children younger than 2 years of age. The effect of Elidel and Protopic on the developing immune system in infants and children is not known. In clinical studies, infants and children younger than 2 years old treated with Elidel had a higher rate of upper respiratory infections than did those treated with placebo cream.
- Use Elidel and Protopic only for short periods of time, not continuously. The long term safety of Elidel and Protopic are unknown.
- Children and adults with a weakened or compromised immune system should not use Elidel or Protopic.
- Use the minimum amount of Elidel or Protopic needed to control the patient's symptoms. In animals, increasing the dose resulted in higher rates of cancer.

http://www.fda.gov/cder/drug/infopage/protopic/default.htm

http://www.fda.gov/cder/drug/advisory/elidel_protopic.htm

Topical Immunomodulators

Preferred Drugs - PA Required	Preferred Drugs - PA Required
Elidel®	
Protopic®	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Leukotriene Receptor Antagonists

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?
   Acceptable reasons include:
   - Allergy to medications not requiring prior approval
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval
   - History of unacceptable/toxic side effects to medications not requiring prior approval

   Document clinically compelling information

2. If there has been a therapeutic failure to the agent not requiring prior approval, then may approve the requested medication.
   Document details

Leukotriene Receptor Antagonists

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Accolate®	~~Zyflo®~~ No longer available
Singulair®	Zyflo CR™

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Lipotropics

LENGTH OF AUTHORIZATIONS: 1 year

General Guidelines:

Currently there are four classes of medications in the Lipotropics with three classes represented in the PDL. Each class has a different mechanism of action and acts on different components of total cholesterol

- Fibric acid derivatives-& Omega 3 agent
- HMG COA reductase Inhibitors
- Nicotinic acid derivatives
- Bile Acid Resins *(not included in VA PDL at this time)*

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval
- Patient's condition is clinically unstable; changing to a medication not requiring prior approval might cause deterioration of the patient's condition.

Document clinically compelling information

2. If there have been therapeutic failures to no less than **one-month** trials of at least **one** medication not requiring prior approval, then may approve the requested medication.
   Document details

3. If documented very high triglycerides of (≥ 500 mg/dL) in adult patients. Then a PA for Omacor®/Lovaza® can be approved with out any specific preferred medication trials**.**

See next pages for specific drug lists.

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Lipotropics
(Continued page 2)

Lipotropics – Fibric Acid Derivatives and Omega 3 agent

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Antara®	Lovaza®
Gemfibrozil	Tricor®
	Triglide®

Lipotropics – Niacin Derivatives

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Niacor®	
Niaspan®	

Lipotropics – Niacin Derivatives & HMG CoA Reductase Inhibitors (Statins) Combination

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Simcor® **	

** Requires a history of either a niacin or Simvastatin product within the past 90 days.

Lipotropics – HMG CoA Reductase Inhibitors and Combinations (Statins)

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Advicor®	Caduet®
Altoprev®	Crestor®
Simvastatin	Lipitor®
Lescol®	Mevacor®
Lescol XL®	Pravachol®
Lovastatin	Vytorin®
Pravastatin	Zocor®

Lipotropics - CAI

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Zetia®	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

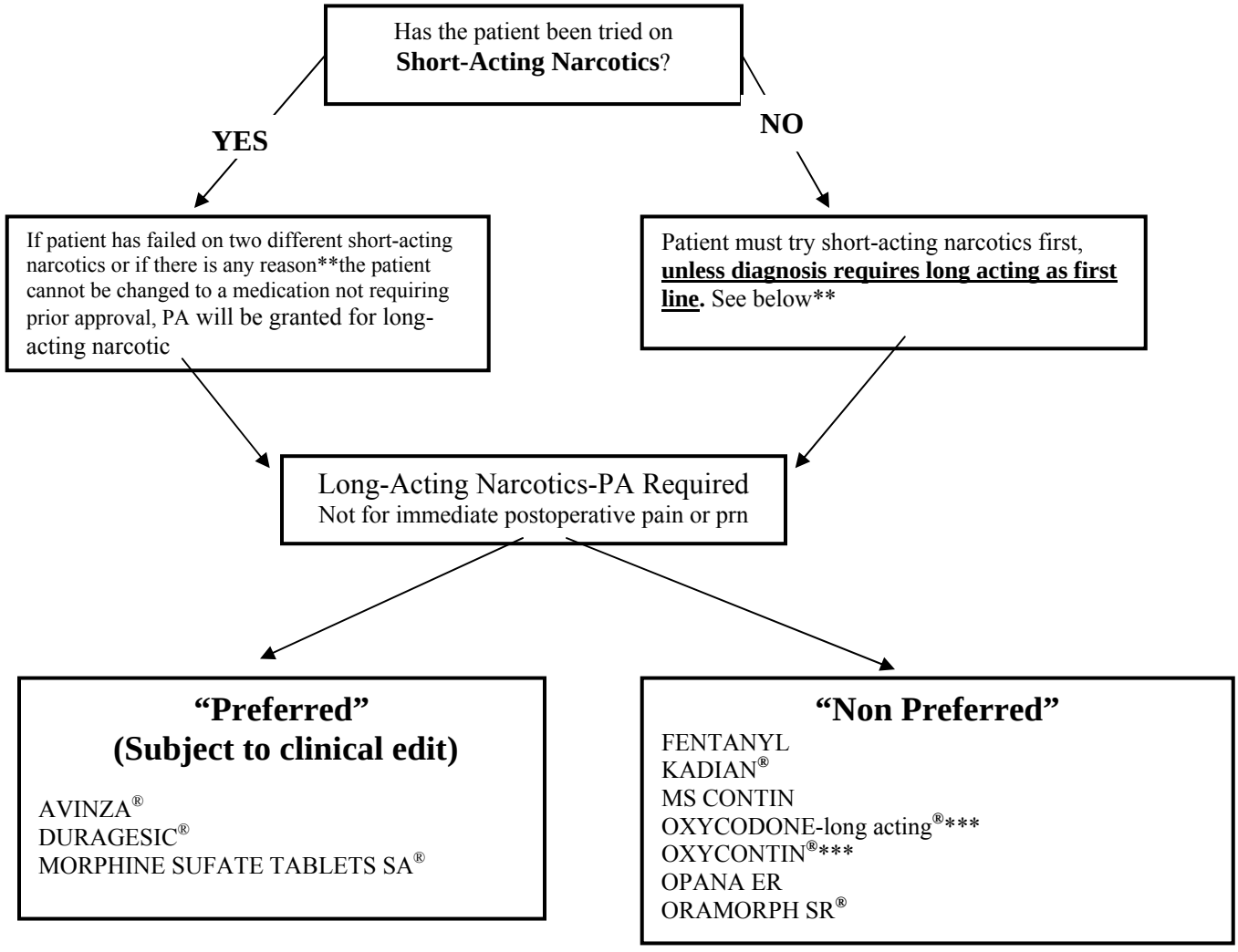
Long Acting Narcotics – Step Therapy

SHORT ACTING NARCOTICS (no PA required)

Butalbital Combinations	Methadone*	Opana
Butalbital w/codeine	Morphine-short acting	
Codeine	Nalbuphine	
Codeine w/APAP	Oxycodone-short acting	
Codeine w/ASA	Oxycodone w/APAP	
Hydrocodone	Oxycodone w/ASA	
Hydrocodone w/APAP	Oxymorphone	
Hydromorphone	Pentazocine combinations	
Levorphanol	Propoxyphene combinations	
Meperidine	Fentora	

**The use of methadone for pain should ideally be done in the context of an organized pain clinic, hospice or with assistance of local pain management experts, including health care providers or pharmacists, who have experience with methadone use.*

Step-Therapy



*New generic, brand, or dose formulation anticipated, will be non-preferred pending review

****Step-Therapy is not required for those patients that have been stabilized on Long Acting Narcotics or need relief of moderate to severe pain requiring around-the-clock opioid therapy, for an extended period of time.** Additional acceptable reasons include:

- Allergy to medications not requiring prior approvals
- Contraindications to or drug-to-drug interaction with medications not requiring prior approval
- *If the patient has a diagnosis that is an approved indication for the medication that requires prior approval and this diagnosis is not an indication for the medications that do not require prior approval.*
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

LENGTH OF AUTHORIZATIONS: 6 months

OxyContin* / Oxycodone-long acting***Guidelines**

1. Coverage is limited to those persons 18 years of age or older with a need for a continuous around-the-clock analgesic for an extended period of time for the management of moderate to severe pain.

2. There are no diagnosis restrictions here. The main objective is to verify appropriate use and the following items should be taken into consideration when reviewing an oxycontin request:

- Dosing frequency greater than bid (tid for an identified, organized pain clinic or pain specialist)
- Dosing using multiple small strength tablets as opposed to a single higher strength tablets
- Odd quantities that would result in fractional dosing
- Patient history of substance abuse
- Frequent early refill attempts
- Multiple request pertaining to lost medication
- Short-term or prn use (oxycontin is not indicated for short-term or prn use)
- Any suspicious use reported by pharmacies or physicians
- A rapid increase in dosage
- 80mg tablets are for opioid tolerant patients only

3. Reasons for denial:
- Split tablets
- Greater than tid dosing frequency
- Concurrent use of other extended release opioids
- Prn dosing

1997 medical society of Virginia and house of delegates guidelines Virginia code 54.1-2971.01 states:

"In the case of a patient with intractable pain, the attending physician may prescribe a dosage in excess of the recommended dosage of a pain relieving agent if he certifies the medical necessity for such excess dosage in the patient's medical record. Any person who prescribes, dispenses or administers an excess dosage in accordance with this section shall not be deemed to be in violation of the provisions of this title because of such excess dosage, if such excess dosage is prescribed, dispensed or administered in good faith for accepted medicinal or therapeutic purposes. Nothing in this section shall be construed to grant any person immunity from investigation or disciplinary action **based on the prescription, dispensing or** administration of an excess dosage in violation of this section."

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

NSAIDs (Non-Steroidal Anti-inflammatory Drugs)

LENGTH OF AUTHORIZATIONS: 1 YEAR

- For COX II clinical edit see page (3)

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. The requested medication may be approved if **both** of the following are true:
   - If there has been a therapeutic failure to no less than a **one-month** trial of at least **two** medication(s) within the same class not requiring prior approval
   - The requested medications corresponding generic (if a generic is available) has been attempted and failed or is contraindicated.

3. If there is a specific indication for a medication requiring prior approval, for which medications not requiring prior approval are not indicated, then document details and refer to a clinical pharmacist.

Clinical Criteria for Flector® & Voltaren gel®:

- Approval is based on patient failing the **Oral** generic of the desired product **and** at least 1 other preferred NSAIDs (to equal a total of at least 2 preferred).
- For example, a patient who failed ibuprofen and naproxen will still need to try oral generic diclofenac for approval of Flector

ADDITIONAL INFORMATION TO CONSIDER

If the patient is allergic to one NSAID or aspirin, the patient may be allergic to other NSAIDs

See next pages for specific drug lists.

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

NSAIDs (Non-Steroidal Anti-inflammatory Drugs) (Page 2)

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Diclofenac potassium	Anaprox®
Diclofenac sodium	Anaprox DS®
Diflunisal	Ansaid®
Etodolac	Arthrotec®
Etodolac SR	Cataflam®
Fenoprofen	Clinoril®
Flurbiprofen	Daypro®
Ibuprofen	Dolobid®
Indomethacin	Feldene®
Indomethacin SR	Flector patch
Ketoprofen	Indocin®
Ketoprofen ER	Indocin SR®
Ketorolac	Lodine®
Meclofenamate sodium	Lodine XL®
Nabumetone	Mefenamic
Naproxen	Meloxicam
Naproxen sodium	Mobic®
Oxaprozin	Motrin®
Piroxicam	Nalfon®
Sulindac	Naprelan®
Tolmetin Sodium	Prevacid Naprapac®
	Naprosyn®
	Orudis®
	Oruvail®
	Ponstel®
	Relafen®
	Tolectin DS®
	Toradol®
	Voltaren®
	Voltaren XR® Voltaren GEL®

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Ophthalmic Antihistamines/Mast Cell Stabilizers

LENGTH OF AUTHORIZATIONS: 1 year

2. Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- Allergy to product formulation (i.e. dyes or fillers). If an allergy to drug class, should question medication request.
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

3. If there has been a therapeutic failure to no less than a **three-day** trial of **one** medication within the same not requiring prior approval, then may approve the requested medication. Document details.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION

If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.

Ophthalmic Antihistamines

Preferred Drugs - No PA Required	Non-Preferred Drugs - PA Required
Elestat drops®	Emadine drops®
Alaway OTC®	~~Zaditor RX drops®~~ No longer available
Optivar drops®	Ketotifen Fumerate
Patanol drops®	
Pataday drops®	
Zaditor OTC drops®	

Ophthalmic Mast Cell Stabilizers

Preferred Drugs - No PA Required	Non-Preferred Drugs - PA Required
Alamast drops®	Crolom drops®
Alocril drops®	
Alomide drops®	
Cromolyn Sodium	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Ophthalmic Anti-inflammatory

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:
- Allergy to product formulation (i.e. dyes, fillers). If an allergy to drug class, should question medication request.
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. If there has been a therapeutic failure to no less than a 3 **day** trial of **one** medication within the same not requiring prior approval, then may approve the requested medication. Document details.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION
If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.

Ophthalmic Anti-Inflammatory

Preferred Drugs - No PA Required	Non-Preferred Drugs - PA Required
Acular drops®	Acular PF droperette®
Acular LS drops®	Ocufen drops®
Flurbiprofen Sodium	
Nevanac drops Susp®	
Voltaren drops®	
Xibrom drops®	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Ophthalmic Fluoroquinolones

LENGTH OF AUTHORIZATIONS: for the date of service only; no refills

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:
- Allergy to product formulation (i.e. dyes, fillers). If an allergy to drug class, should question medication request.
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. If the infection is caused by an organism resistant to medications not requiring prior approval, then may approve the requested medication. Document details.
   - Note diagnosis and any culture and sensitivity reports

3. If there has been a therapeutic failure to no less than a **three-day** trial of **one** medication within the same not requiring prior approval, then may approve the requested medication. Document details.

ADDITIONAL INFORMATION TO AID IN THE FINAL DECISION
If the patient is completing a course of therapy with a medication requiring prior approval, which was initiated in the hospital, then may approve the requested medication to complete the course of therapy.

Ophthalmic Fluoroquinolones

Preferred Drugs - No PA Required	Non-Preferred Drugs - PA Required
Ciprofloxacin drops	Ciloxan drops®
Ofloxacin drops	Ciloxan oint®
Quixin drops®	Ocuflox drops®
Vigamox drops®	
Zymar drops®	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Oral Hypoglycemics

LENGTH OF AUTHORIZATIONS: 1 Year

1. Is there any reason the patient cannot be switched to a non-prior approved medication?

Acceptable reasons include:

- Allergy to the non-prior approved products in this class
- Contraindication or drug to drug interaction with all non-prior approved products
- History of unacceptable side effects

Document clinically compelling information

2. Has the patient tried and failed a therapeutic trial of thirty days with **one** of the non-preferred drugs **within the same class**? If so, document and approve the prior authorized drugs.

See next pages for specific drug lists.

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Oral Hypoglycemics

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Alpha-Glucosidase Inhibitors	
Glyset®	
Precose®	
Biguanides	
Metformin	Glucophage®
Metformin ER	Glucophage XR®
	Glutmetza®
	Fortamet®
	Riomet® suspension
Biguanide Combination Products	
Avandamet®	Glucovance®
Glipizide/metformin	Metaglip®
Glyburide/metformin	
DPP-IV inhibitors and combination	
Januvia®	
Janumet®	
Meglitinides	
Starlix® ***(Nateglinide)**	Prandin®
Thiazolidinediones	
Actos®	Avandryl®
Avandia®	Duetact®
Actoplus Met®	
Second Generation Sulfonylureas	
Glipizide	Amaryl®
Glipizide ER	Diabeta®
Glyburide	Glucotrol®
Glyburide micronized	Glucotrol XL®
Glimepiride	Glynase®
	Micronase®

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Osteoporosis Agents – Bisphosphonates

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medication not requiring prior approval
- Contraindication to or drug-to-drug interaction with medication not requiring prior approval
- History of unacceptable/toxic side effects to medication not requiring prior approval

Document clinically compelling information

2. Has the patient tried and failed a therapeutic trial with a preferred drug **within the same class**? If so, document and approve the prior authorized drug.

Bisphosphonates

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Actonel®	Actonel with calcium®
Fosamax®	*(*Actonel 150mg®)*
Fosamax® solution	Aledronate
Fosamax plus D®	Boniva®

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Phosphodiesterase 5 Inhibitors
Pulmonary Arterial Hypertension

LENGTH OF AUTHORIZATIONS: 1 year

Diagnosis of Pulmonary Hypertension in patients 18 years of age or older is required.

The requested medication may be approved if both of the following are true:

- The prescribing physician is a pulmonary specialist or cardiologist.
- Client has documented Pulmonary Arterial Hypertension and will be followed by the prescribing physician.

Document clinically supporting information

Contraindications where the PA should not be approved:

- Concurrent use of nitrates (e.g., nitroglycerin)
- Hypersensitivity to Sildenafil.

PD5 Inhibitor

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Revatio®	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Sedative/ Hypnotics

LENGTH OF AUTHORIZATIONS: Length of the prescription (up to 3 months)

2. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

3. **To receive a non preferred benzodiazepine** there must have been a therapeutic failure to no less than a **one-month** trial of at least **one benzodiazepine** not requiring prior approval, then may approve the requested medication.
   Document details

4. **To receive a preferred non benzodiazepine** there must have been a therapeutic failure to no less than a **one-month** trial of a benzodiazepine *(step edit)*

5. **To receive a non preferred non benzodiazepine** there must have been a therapeutic failure to no less than a **one-month** trial of
   - First a benzodiazepine *(step edit)*
   - Second a therapeutic failure to not less than a **one-month** trial of Rozerem®
   - Then may approve the requested medication.

   Document details

6. If a request for Ambien® is received for a pregnant patient, approve the Ambien® for the duration of the prescription or the duration of the pregnancy (whichever is shorter).

7. For **patients age 65 and older**, Rozerem®, Ambien® or Lunesta® may be approved after a trial of trazodone (duration = at least one month). It is not necessary for patient's ≥ 65 to try a benzodiazepine if they have had a trial of trazodone.

See next pages for specific drug lists.

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Sedative/ Hypnotics
(Page 2)

Sedative Hypnotics (Benzodiazepine)

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Estazolam	Dalmane®
Flurazepam	Doral®
Temazepam	Halcion®
Triazolam	Prosom®
Chloral hydrate Syrup	Restoril®

Sedative Hypnotics (Non-Benzodiazepine) ***See step edit***

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Rozerem® **	Ambien®
Zolpidem	Ambien CR®
	Lunesta®
	Somnote®
	Sonata®
	***(Tovalt ODT)**
	***(Zaleplon)**

** Must meet Step edit as noted above to receive Rozerem®

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*

Urinary Antispasmodics

LENGTH OF AUTHORIZATIONS: 1 year

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval within the same class?

Acceptable reasons include:

- Allergy to medications not requiring prior approval
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval
- History of unacceptable/toxic side effects to medications not requiring prior approval

Document clinically compelling information

2. If there has been a therapeutic **failure to at least a one-month trial of at least one medication** not requiring prior approval, then may approve the requested medication.

Urinary Antispasmodics

Preferred Drugs - No PA Required	Non-preferred Drugs - PA Required
Detrol LA®	Detrol®
Enablex®	Ditropan®
Oxybutynin Tablet	Ditropan XL®
Oxybutynin Syrup	Oxybutynin ER
Oxytrol® Transdermal	
Sanctura®	
Sanctura XR®	
Vesicare®	

**New generic, brand, or dose formulation anticipated, will be non-preferred pending review*